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CHAPTER V

BILLING INSTRUCTIONS

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CHAPTER V BILLING INSTRUCTIONS

INTRODUCTION

Claims for services must be submitted to Medicaid on the appropriate billing invoice with the use of the billing codes as explained in the instructions for each invoice. Submit invoices by mail to:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800) 924-6741
Fax number: (804)-273-6797
E-mail: edivmap@fhsc.com
First Health's Website: <http://virginia.fhsc.com>, or by mail:

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

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- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.
- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified through a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the dated letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Denied Claims** - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:
 - Complete the CMS-1500 (12-90) invoice as explained under the "Instructions for the Use of the CMS-1500 (12-90) Billing Form" elsewhere in this chapter.
 - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See Exhibits).
 - Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.
 - Submit the claim in the usual manner by mailing the claim to:

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Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:
 - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.
 - The claim is related to a Medicare claim, which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.
 - This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.
 - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those affected by it.

The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.
- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the

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service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

BILLING INVOICES

The requirements for submission of billing information and the use of the appropriate billing invoice depend upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the three billing invoices to be used for billing vision care services:

- Health Insurance Claim Form CMS-1500 (12-90)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) (Rev 6/03)
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31 Rev 6/96)

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) claim form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms, which can be downloaded from the DMAS web site (www.dmas.virginia.gov) (*please note the new DMAS web site address*). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call: 1-(804)-780-0076.

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REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pending, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800)-924-6741.

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

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Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers

| | |
|----------------|--|
| 1-804-786-6273 | Richmond Area and out-of-state long distance |
| 1-800-552-8627 | In-state long distance (toll-free) |

Enrollee verification and claim status may be obtained by telephoning:

| | |
|-----------------|--|
| 1-800- 772-9996 | Toll-free throughout the United States |
| 1-800-884-9730 | Toll-free throughout the United States |
| (804) 965-9732 | Richmond and Surrounding Counties |
| (804) 965-9733 | Richmond and Surrounding Counties |

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

The appropriate claim form or billing invoice must be used by physicians and other practitioners when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will be ended for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

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DMAS will accept National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of profession claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.
- Unsolicited 277 for reporting information on pending claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pending claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <http://virginia.fhsc.com>.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

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INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found later in this Chapter.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), Billing Invoice

The purpose of the CMS-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed CMS-1500 claim form follows the instructions for its use).

| Locator | Instructions |
|--------------------|--|
| 1 REQUIRED | Enter an "X" in the MEDICAID box. |
| 1a REQUIRED | Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service. |
| 2 REQUIRED | Patient's Name - Enter the name of the recipient receiving the service. |
| 3 NOT REQUIRED | Patient's Birth Date |
| 4 NOT REQUIRED | Insured's Name |
| 5 NOT REQUIRED | Patient's Address |
| 6 NOT REQUIRED | Patient Relationship to Insured |
| 7 NOT REQUIRED | Insured's Address |
| 8 NOT REQUIRED | Patient Status |
| 9 NOT REQUIRED | Other Insured's Name |
| 9a NOT REQUIRED | Other Insured's Policy or Group Number |
| 9b NOT REQUIRED | Other Insured's Date of Birth and Sex |
| 9c NOT REQUIRED | Employer's Name or School Name |
| 9d NOT REQUIRED | Insurance Plan Name or Program Name |

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| Locator | | Instructions |
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| 10 | REQUIRED | Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.) |
| 10d | CONDITIONAL | Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used. |
| 11 | NOT REQUIRED | Insured's Policy Number or FECA Number |
| 11a | NOT REQUIRED | Insured's Date of Birth |
| 11b | NOT REQUIRED | Employer's Name or School Name |
| 11c | NOT REQUIRED | Insurance Plan or Program Name |
| 11d | NOT REQUIRED | Is There Another Health Benefit Plan? |
| 12 | NOT REQUIRED | Patient's or Authorized Person's Signature |
| 13 | NOT REQUIRED | Insured's or Authorized Person's Signature |
| 14 | NOT REQUIRED | Date of Current Illness, Injury, or Pregnancy |
| 15 | NOT REQUIRED | If Patient Has Had Same or Similar Illness |
| 16 | NOT REQUIRED | Dates Patient Unable to Work in Current Occupation |
| 17 | CONDITIONAL | Name of Referring Physician or Other Source |
| 17a | CONDITIONAL | I.D. Number of Referring Physician - Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services. |
| 18 | NOT REQUIRED | Hospitalization Dates Related to Current Services |
| 19 | NOT REQUIRED | Reserved for Local Use |
| 20 | CONDITIONAL | CLIA # |
| 21 | REQUIRED | Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis, which describes |

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| Locator | | Instructions |
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| | | the nature of the illness or injury for which the service was rendered. |
| 22 | CONDITIONAL | Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices. |
| 23 | CONDITIONAL | Prior Authorization Number - Enter the PA number for the approved service. |
| 24A | REQUIRED | Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/99). DATES MUST BE WITHIN THE SAME CALENDAR MONTH. |
| 24B | REQUIRED | Place of Service - Enter the 2-digit national place of service code, which describes where the services were rendered. |
| 24C | REQUIRED | Type of Service - Enter the one-digit national code for the type of service rendered. |
| 24D | REQUIRED | <p>Procedures, Services or Supplies CPT/HCPCS - Enter the 5-character CPT/HCPCS Code, which describes the procedure rendered, or the service provided. See the attached code list for special instructions if appropriate for your service.</p> <p>Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.</p> |
| 24E | REQUIRED | Diagnosis Code - Enter the entry identifier of the ICD-9-CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable. When billing procedure codes 99281-99285, enter values of 1, 2, 3, and 4 only. The numbers are intended to relate the procedures back to the ICD-9-CM diagnosis code in Locator 21. The CMS-1500 (12-90) can accommodate up to four ICD-9-CM diagnosis codes in Locator 21. Claims with values other than 1, 2, 3, or 4 in Locator 24-E may be denied. Must be values 1, 2, 3 or 4 only. |

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| Locator | Instructions |
|------------------------|---|
| 24F REQUIRED | Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service. |
| 24G REQUIRED | Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service. |
| 24H CONDITIONAL | <p>EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.</p> <p>1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services</p> <p>2 - Family Planning Service</p> |
| 24I CONDITIONAL | EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency. |
| 24J REQUIRED | <p>COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.</p> <p>2 - No Other Carrier</p> <p>3 - Billed and Paid</p> <p>5 - Billed, No Coverage. All claims submitted with a Coordination of Benefits (COB) code of 5 must have an attachment documenting one of the following:</p> <ul style="list-style-type: none"> • The Explanation of Benefits (EOB) from the primary carrier; or • A statement from the primary carrier that there is no coverage for this service; or • An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or • A statement from the provider indicating that |

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| Locator | Instructions |
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the primary insurance has been canceled.

Claims with no attachment will be denied for reason 495, "Other Insurance Information Missing." Providers who submit claims electronically must indicate a value of "6" in field 38 (*Document Indicator*) of the EA0 record and a value of "B" in field 39 (*Type of Documentation*) to indicate that there is an attachment to this claim. In addition, the HA0 record, *Service Line Narrative*, must contain a narrative description of the information that is on file in the provider's office to support COB code 5 for the claim being submitted.

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| 24K | REQUIRED | Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service. |
| 25 | NOT REQUIRED | Federal Tax I.D. Number |
| 26 | OPTIONAL | Patient's Account Number – Up to seventeen alpha-numeric characters are acceptable. |
| 27 | NOT REQUIRED | Accept Assignment |
| 28 | NOT REQUIRED | Total Charge |
| 29 | NOT REQUIRED | Amount Paid |
| 30 | NOT REQUIRED | Balance Due |
| 31 | REQUIRED | Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block. |
| 32 | NOT REQUIRED | Name and Address of Facility Where Services Were Rendered |
| 33 | REQUIRED | Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number (servicing provider) in the PIN # field. Ensure that your provider number is distinct and separate from |

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Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

- 1023 Primary Carrier has made additional payment
- 1024 Primary Carrier has denied payment
- 1025 Accommodation charge correction
- 1026 Patient payment amount changed
- 1027 Correcting service periods
- 1028 Correcting procedure/service code
- 1029 Correcting diagnosis code
- 1030 Correcting charges
- 1031 Correcting units/visits/studies/procedures
- 1032 IC reconsideration of allowance, documented
- 1033 Correcting admitting, referring, prescribing, provider identification number
- 1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

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Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

- 1042 Original claim has multiple incorrect items
- 1044 Wrong provider identification number
- 1045 Wrong enrollee eligibility number
- 1046 Primary carrier has paid DMAS maximum allowance
- 1047 Duplicate payment was made
- 1048 Primary carrier has paid full charge
- 1051 Enrollee not my patient
- 1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim).

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SPECIAL BILLING INSTRUCTIONS - CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM). Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR SPECIAL INSTRUCTIONS

- | | |
|-----|--|
| 10d | Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate. |
| 17a | When a restricted enrollee is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d. |
| 24I | When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d. |

EDI Billing (Electronic Claims)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

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SPECIAL BILLING INSTRUCTIONS - MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the CMS-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

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SPECIAL BILLING INSTRUCTIONS

VISION MANUAL

Locator 21 **Diagnosis or Nature of Illness or Injury** - Enter the diagnosis code V720 for routine eye exams and for eyeglasses; otherwise, enter the appropriate ICD-9-CM diagnostic code.

Locator 24D **Procedures, Services, or Supplies** - Enter the applicable code. See Appendix B for the codes for routine eye exams and for eyeglasses; otherwise, use the appropriate HCPCS code.

Locator 24G **Days or Units** - For eyeglasses, one lens is considered one unit; two lenses, two units. Eyeglass frames are considered one unit.

When a Medicare vision care provider bills Medicare for a medical procedure and an eye refraction is part of the service, the refraction is not covered by Medicare. Medicare denies it as a non-covered service. To bill Medicaid for the refraction, use CPT procedure code 92015 (determination of refractive state) on the CMS-1500 (12-90) form. Place a "5" in block 24J and attach the denial from Medicare.

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INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part A and Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part A and B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part A and Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part A and Part B carrier is one of those serving Virginia and the Virginia Medicaid Program, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 R 6/03 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

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Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 Provider's Medicaid ID Number – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 Recipient's Last Name – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 Recipient's First Name – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 Recipient ID Number – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 Patient's Account Number – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 Recipient's HIB Number (Medicare) – Enter the enrollee's Medicare number.

Block 07 Primary Carrier Information (Other Than Medicare) – Check the appropriate block. (Medicare is not the primary carrier in this situation).

Code 2 – No Other Coverage – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

Code 3 – Billed and Paid – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

Code 5 – Billed and No Coverage – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

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- Block 08** Type of Coverage (Medicare) – Mark type of coverage B only.
- Block 09** Diagnosis – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.
- Block 10** Place of Treatment – Enter the appropriate national place of service code.
- Block 11** Accident/Emergency Indicator – Check the appropriate box, which indicates the reason the treatment, was rendered:
- **ACC** – Accident, Possible third-party recovery
 - **Emer** – Emergency, Not an accident
 - **Other** – If none of the above
- Block 12** Type of Service – Enter the appropriate national code describing the type of service.
- Block 13** Procedure Code – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.
- Block 14** Visits/Units/Studies – Enter the units of service performed during the “Statement Covers Period” (block 16) as billed to Medicare.
- Block 15** Date of Admission – Enter the date of admission (if applicable).
- Block 16** Statement Covers Period – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).
- Block 17** Charges to Medicare – Enter the total charges submitted to Medicare.
- Block 18** Allowed by Medicare – Enter the amount of the charges allowed by Medicare.
- Block 19** Paid by Medicare – Enter the amount paid by Medicare (taken from the Medicare EOMB).
- Block 20** Deductible – Enter the amount of the deductible (taken from the Medicare EOMB).
- Block 21** Co-insurance – Enter the amount of the co-insurance (taken from the Medicare EOMB).
- Block 22** Paid by Carrier Other Than Medicare – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7,

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enter an amount in this block. (Do not include Medicare payments).

Block 23 Patient Pay Amount, LTC Only – Enter the patient pay amount, if applicable.

Block 24 Remarks – If an explanation regarding this claim is necessary, the “Remarks” section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

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Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice FOR PART B ONLY, DMAS-31 (R 6/96)

Adjustment Coinsurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Coinsurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must be identical to the original invoice.

- | | |
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| Purpose | To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form). |
| Explanation | To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have. |
| Block 1 | Adjustment/Void - Check the appropriate block. |
| Block 2 | Provider Identification Number – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid. |
| Block 2A | Reference Number - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice. |
| Block 2B | Reason - Leave blank. |
| Block 2C | Input Code - Leave blank. |
| Block 3 | Clients' Name - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card. |
| Block 4 | Client's Identification Number - Enter the 12-digit number taken from the enrollee's eligibility card. |
| Block 5 | Patient Account Number – Enter the financial account number assigned by the provider. This number will appear on the |

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Remittance voucher after the claim is processed.

- Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.
- Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).
- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
 - **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
 - **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.
- Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".
- Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.
- Block 9A **Place of Treatment** - Enter the appropriate national place of service code:
- Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:
- **Accident** - Possible third-party recovery
 - **Emergency** - Not an accident
 - **Other** - If none of the above
- Block 11 **Type of Service** - Enter the appropriate national code describing the type of service.
- Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this

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blank. Use the appropriate national procedure code modifier if applicable

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare. (Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

**Mechanics
and
Disposition**

The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Retain a copy for the office files.

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INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

Turnaround Document Letter (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to FHS. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher
 - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
 - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual*.

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PLEASE
DO NOT
STAPLE
IN THIS
AREA

| PICA | | | | | | | | | | HEALTH INSURANCE CLAIM FORM | | | | | | | | | | PICA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. MEDICARE (Medicare #) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | MEDICAID (Medicaid #) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | CHAMPUS (Sponsor's SSN) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | CHAMPVA (VA File #) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | GROUP HEALTH PLAN (SSN or ID) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | FECA BLK LUNG (SSN) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | OTHER (ID) [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY M SEX F | | | | | | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self [] Spouse [] Child [] Other [] | | | | | | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CITY | | | | | | | | | | | | | | | STATE | | | | | | | | | | | | | | | CITY | | | | | | | | | | | | | | | STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ZIP CODE | | | | | | | | | | | | | | | TELEPHONE (include Area Code) () () () () () () | | | | | | | | | | | | | | | ZIP CODE | | | | | | | | | | | | | | | TELEPHONE (INCLUDE AREA CODE) () () () () () () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | a. EMPLOYMENT? (CURRENT OR PREVIOUS) [] YES [] NO | | | | | | | | | | a. INSURED'S DATE OF BIRTH MM DD YY M SEX F | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY M SEX F | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | b. AUTO ACCIDENT? [] YES [] NO PLACE (State) [] [] | | | | | | | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | c. OTHER ACCIDENT? [] YES [] NO | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [] YES [] NO If yes, return to end complete item 9 a-d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED _____ | | | | | | | | | | | | | | | DATE _____ | | | | | | | | | | | | | | | SIGNED _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY | | | | | | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | | | | | | | | | | | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? \$ CHARGES [] YES [] NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 2. _____ 3. _____ 4. _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. A DATE(S) OF SERVICE To From MM DD YY MM DD YY | | | | | | | | | | B Place of Service | | | | | | | | | | C Type of Service | | | | | | | | | | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | | | | | | | | | E DIAGNOSIS CODE | | | | | | | | | | F \$ CHARGES | | | | | | | | | | G DAYS OR UNITS | | | | | | | | | | H ERSDT Family Plan | | | | | | | | | | I EMG | | | | | | | | | | J COB | | | | | | | | | | K RESERVED FOR LOCAL USE | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | | | | | | SSN EIN [] [] [] [] [] [] [] [] [] [] | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | | | | | | 27. ACCEPT ASSIGNMENT? (For govt claims, see back) [] YES [] NO | | | | | | | | | | 28. TOTAL CHARGE \$ | | | | | | | | | | 29. AMOUNT PAID \$ | | | | | | | | | | 30. BALANCE DUE \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PIN# | | | | | | | | | | | | | | | GRP# | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8.88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

| | | | | | | | | | | | |
|----------------------------------|--|--|--|-----------------------------|--|--|--|--------------------------------------|--|--|--|
| 01 Provider's Medicaid ID Number | | | | 02 Last Name | | | | 03 First Name | | | |
| 04 Recipient ID Number | | | | 05 Patient's Account Number | | | | 06 Recipient's HIB Number (Medicare) | | | |

| | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--------------------------|--|--|--|------------------------|--|---------------------|--|--------------------------|--|
| 1 07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage | | 08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B | | 09 Diagnosis | | 10 Place of Treatment | | 11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other | | 12 Type of Service | | 13 Procedure Code | | 14 Visits/Units, Studies | |
| 15 Date of Admission MM DD YY | | From MM DD | | 16 Statement Covers Period MM DD YY | | Thru MM DD YY | | 17 Charges to Medicare | | 18 Allowed By Medicare | | 19 Paid By Medicare | | | |
| 20 Deductible | | 21 Co-Insurance | | 22 Paid By Carrier Other Than Medicare | | 23 Pat Pay Amt. LTC Only | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--------------------------|--|--|--|------------------------|--|---------------------|--|--------------------------|--|
| 2 07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage | | 08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B | | 09 Diagnosis | | 10 Place of Treatment | | 11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other | | 12 Type of Service | | 13 Procedure Code | | 14 Visits/Units, Studies | |
| 15 Date of Admission MM DD YY | | From MM DD | | 16 Statement Covers Period MM DD YY | | Thru MM DD YY | | 17 Charges to Medicare | | 18 Allowed By Medicare | | 19 Paid By Medicare | | | |
| 20 Deductible | | 21 Co-Insurance | | 22 Paid By Carrier Other Than Medicare | | 23 Pat Pay Amt. LTC Only | | | | | | | | | |

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|--|--|---|--|--|--|--------------------------|--|--|--|------------------------|--|---------------------|--|--------------------------|--|
| 3 07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage | | 08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B | | 09 Diagnosis | | 10 Place of Treatment | | 11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other | | 12 Type of Service | | 13 Procedure Code | | 14 Visits/Units, Studies | |
| 15 Date of Admission MM DD YY | | From MM DD | | 16 Statement Covers Period MM DD YY | | Thru MM DD YY | | 17 Charges to Medicare | | 18 Allowed By Medicare | | 19 Paid By Medicare | | | |
| 20 Deductible | | 21 Co-Insurance | | 22 Paid By Carrier Other Than Medicare | | 23 Pat Pay Amt. LTC Only | | | | | | | | | |

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|--|--|---|--|--|--|--------------------------|--|--|--|------------------------|--|---------------------|--|--------------------------|--|
| 4 07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage | | 08 Type Of Coverage Medicare <input type="checkbox"/> A <input type="checkbox"/> B | | 09 Diagnosis | | 10 Place of Treatment | | 11 Accident / Emer Ind <input type="checkbox"/> ACC <input type="checkbox"/> Emer <input type="checkbox"/> Other | | 12 Type of Service | | 13 Procedure Code | | 14 Visits/Units, Studies | |
| 15 Date of Admission MM DD YY | | From MM DD | | 16 Statement Covers Period MM DD YY | | Thru MM DD YY | | 17 Charges to Medicare | | 18 Allowed By Medicare | | 19 Paid By Medicare | | | |
| 20 Deductible | | 21 Co-Insurance | | 22 Paid By Carrier Other Than Medicare | | 23 Pat Pay Amt. LTC Only | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 24 Remarks | | | | | | | | | | | | | | | |
|------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE

DATE

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

- Block 01** **Provider's Medicaid ID Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.
- Block 02** **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.
- Block 03** **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.
- Block 04** **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.
- Block 05** **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.
- Block 06** **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.
- Block 07** **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation).
- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
 - **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
 - **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.
- Block 08** **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.
- Block 09** **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.
- Block 10** **Place of Treatment** – Enter the appropriate national place of service code.
- Block 11** **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:
- **ACC** – Accident, Possible third-party recovery
 - **Emer** – Emergency, Not an accident
 - **Other** – If none of the above
- Block 12** **Type of Service** – Enter the appropriate national code describing the type of service.
- Block 13** **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.
- Block 14** **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

| | |
|------------------|--|
| Block 15 | Date of Admission – Enter the date of admission (if applicable) |
| Block 16 | Statement Covers Period – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03). |
| Block 17 | Charges to Medicare – Enter the total charges submitted to Medicare. |
| Block 18 | Allowed by Medicare – Enter the amount of the charges allowed by Medicare. |
| Block 19 | Paid by Medicare – Enter the amount paid by Medicare (taken from the Medicare EOMB). |
| Block 20 | Deductible – Enter the amount of the deductible (taken from the Medicare EOMB). |
| Block 21 | Co-insurance – Enter the amount of the co-insurance (taken from the Medicare EOMB). |
| Block 22 | Paid by Carrier Other Than Medicare – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments). |
| Block 23 | Patient Pay Amount, LTC Only – Enter the patient pay amount, if applicable. |
| Block 24 | Remarks – If an explanation regarding this claim is necessary, the “Remarks” section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim. |
| Signature | Note the certification statement on the claim form, then sign and date the claim form. |

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE
VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

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|---|--|--|------------|--------------------------|--|---------------------------------|--|---|---------------------------|---|--|--------------------------------------|--|------------------------------|--|---|--|---|--|
| 1. ADJUSTMENT <input type="checkbox"/> 092 | | VOID <input type="checkbox"/> 094 | | 2. PROVIDER I.D. NO. (7) | | A. REFERENCE NUMBER (9) | | B. REASON | | C. INPUT CODE | | | | | | | | | |
| 3. RECIPIENT'S LAST NAME | | | FIRST NAME | | | 4. RECIPIENT'S I.D. NUMBER (12) | | | 5. PATIENT ACCOUNT NUMBER | | | 6. RECIPIENT'S HHS NUMBER (MEDICARE) | | | | | | | |
| 7. PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE) <input type="checkbox"/> 2 NO OTHER COVERAGE <input type="checkbox"/> 3 BILLED AND PAID <input type="checkbox"/> 5 BILLED NO COVERAGE | | 8. TYPE COVERAGE (MEDICARE) <input type="checkbox"/> A <input type="checkbox"/> B | | 9. DIAGNOSIS | | 10A. PLACE OF TREAT | | 10. ACCIDENT/EMERG. INDICATOR <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E | | 11. TYPE SERV | | 12. PROCEDURE CODE (5) | | 13. VISITS/UNITS STUDIES (2) | | 14. DATE OF ADMISSION MO: (2) DAY: (2) YEAR: (2) | | 15. STATEMENT COVERS PERIOD FROM MO: (2) DAY: (2) YEAR: (2) THRU MO: (2) DAY: (2) YEAR: (2) | |
| 16. CHARGES TO MEDICARE | | 17. ALLOWED BY MEDICARE | | 18. PAID BY MEDICARE | | 19. DEDUCTIBLE | | 20. COINSURANCE | | 21. PAID BY CARRIER OTHER THAN MEDICARE | | 22. PATIENT PAY AMOUNT LTC ONLY | | | | | | | |

_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

ORIGINAL COPY

SIGNATURE _____

DATE _____

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS-31 (REVISED 6/96)

- Purpose** To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the “Exhibits” section at the end of this chapter for a sample of this form).
- Explanation** To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.
- Block 1 **Adjustment/Void** - Check the appropriate block.
- Block 2 **Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.
- Block 2A **Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.
- Block 2B **Reason** - Leave blank.
- Block 2C **Input Code** - Leave blank.
- Block 3 **Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.
- Block 4 **Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.
- Block 5 **Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.
- Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.
- Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).
- **Code 2 - No Other Coverage**—If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
 - **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and

coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

| | |
|-----------|--|
| Block 8 | Type Coverage (Medicare) - Mark type of coverage "B". |
| Block 9 | Diagnosis - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed. |
| Block 9A | Place of Treatment - Enter the appropriate national place of service code: |
| Block 10 | <p>Accident Indicator - Check the appropriate box which indicates the reason the treatment was rendered:</p> <ul style="list-style-type: none"> • Accident - Possible third-party recovery • Emergency - Not an accident • Other - If none of the above |
| Block 11 | Type of Service - Enter the appropriate national code describing the type of service. |
| Block 11A | Procedure Code - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if applicable. |
| Block 11B | Visits/Units/Studies - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare. (Block 13) |
| Block 12 | Date of Admission - Enter the date of admission (if applicable). |
| Block 13 | Statement Covers Period - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03. |
| Block 14 | Charges to Medicare - Enter the total charges submitted to Medicare. |
| Block 15 | Allowed by Medicare - Enter the amount of the charges allowed by Medicare. |
| Block 16 | Paid by Medicare - Enter the amount paid by Medicare (taken from the EOMB). |
| Block 17 | Deductible - Enter the amount of the deductible (taken from the Medicare EOMB). |
| Block 18 | Coinsurance - Enter the amount of the coinsurance (taken from the Medicare EOMB). |

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

**Mechanics
And
Disposition**

The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Retain a copy for the office files.